STATE OF NEW JERSEY OFFICE OF THE STATE COMPTROLLER

MEDICAID FRAUD DIVISION WORK PLAN Fiscal Year 2013

A. Matthew Boxer COMPTROLLER

Mark Anderson DIRECTOR

I.

The Medicaid Fraud Division of the Office of the State Comptroller

The mission of the Medicaid Fraud Division (MFD) of the Office of the State Comptroller is to prevent, detect, audit, and investigate fraud, waste and abuse by providers and recipients enrolled in the New Jersey Medicaid program, and to recover improperly expended state funds. MFD functions independently from the state agencies it oversees. MFD's work plan for fiscal year (FY) 2013 is outlined in detail below. The work plan is subject to change based on changes to resource allocation and unforeseen events that may shift the MFD's priorities. The purpose of the work plan is to serve as a roadmap for providers, managed care organizations, policy makers, and taxpayers to follow as a guide to MFD's audit and investigative activities planned for state fiscal year 2013.

The items discussed below are not exhaustive, and therefore should not be construed to include all items that MFD intends to address during the year.

II.

Overview

During state fiscal years FY 2011 and 2012, the state's Division of Medical Assistance and Health Services (DMAHS) shifted its focus from fee-for-service programs to managed care. With the exception of Medicaid recipients in long term care facilities or receiving behavioral health services, all recipients were transitioned to one of four Medicaid Managed Care Organizations (MCOs). For the first time, the state's contracts with the MCOs explicitly grant MFD has the ability to audit and investigate providers in the MCO networks, and to recover any and all identified overpayments. Consequently, MFD's most significantly enhanced priority in FY 2013 is investigating and auditing providers and recipients within the MCO networks. To facilitate this transition, MFD has begun data mining encounter analysis of claims data to identify questionable network providers and recipients. We remain committed to working with the MCOs in the coordination of investigative and auditing initiatives to strengthen the state's program integrity function.

The Affordable Care Act of 2010 (ACA) required each state to incorporate a Medicaid Recovery Audit Contractor (RAC) into its state Medicaid integrity plan. DMAHS, with input from MFD, selected Health Management Systems (HMS) to serve as New Jersey's RAC. MFD is responsible for coordinating the RAC's activities with other agencies conducting audits and, to the extent possible, preventing providers from being overburdened by overlapping or simultaneous audits. MFD also coordinates the RAC's efforts with state and federal law enforcement efforts.

To facilitate MFD's coordination activities, the RAC submits a list of proposed audit projects to MFD and DMAHS for approval. Once approved, the RAC audits both fee-for-service and managed care providers to identify overpayments and underpayments. In August 2011, the RAC commenced its initial audits, and to date has recovered over \$4 million for the state. If a RAC audit reveals issues that require an expanded audit or investigation, the RAC refers the case to MFD. Through the end of FY 2012, the RAC has referred three matters to the MFD.

MFD also coordinates with the federal government concerning other outside auditing activities. The federal Centers for Medicare and Medicaid Services (CMS) supervises the Audit Medicaid Integrity Contractor program. During FY 2012, CMS offered MFD the assistance of the Audit Medicaid Integrity Contractor for New Jersey, the Island Peer Review Organization (IPRO). MFD has been working with IPRO on audits and clinical reviews involving hospice and long term care providers. We expect that our working relationship with IPRO will continue and expand to include the review of additional provider groups in FY 2013.

III.

Fiscal Year 2013 Objectives

MFD is charged with, among other things, recovering improperly expended Medicaid dollars from both providers and recipients. Below are the areas where MFD will concentrate its efforts to recover such dollars in FY 2013.

Adult Medical Day Care Services

The Adult Medical Day Care program was moved into managed care for FY 2012. MFD will continue to monitor these programs to ensure that the Medicaid enrollees who are receiving these services are medically qualified to participate; that recipients are receiving the care and services that were ordered; that those services are appropriately billed; that these individuals are receiving the appropriate quality of care; and that providers follow each recipient's plan of care.

Federally Qualified Health Centers

During FY 2012, MFD began its first audit of a Federally Qualified Health Center (FQHC). MFD plans to complete this audit in FY 2013, and will conduct an additional FQHC audit in FY 2013. In general, MFD's review encompasses the adequacy of policies and procedures manuals, staffing composition, employee licenses, relevant employment contracts, patient medical records, quarterly reports, quarterly wrap around reports and all applicable managed care contracts and remittance advice documentation. MFD will test the medical necessity and appropriateness of claims billed to the State for reimbursement.

Home Health Services

Home Health Agencies (HHAs) provide skilled nursing services, home health aide services and medical supplies and equipment to Medicaid recipients. HHAs submit claims to the State in order to receive compensation for the services they provide.

MFD will ensure that reimbursement for these services is provided in accordance with the medical need(s) of the individual recipients, and that services are provided and documented in compliance with all applicable staffing, licensing and documentation regulations and related industry policy and procedures.

MFD will audit and/or investigate these agencies to, among other things, verify that the recipient's diagnosis justifies the higher reimbursement rate for home health services; that charts contain adequate documentation and care plans; and that services billed were in fact rendered.

Hospice Services

MFD will review recipient records to confirm that all necessary criteria for hospice care eligibility have been met. MFD will also identify potential fraudulent billings such as unnecessary services or duplicate billings and interview providers, staff, ordering physicians, or home care workers when there are billing concerns that necessitate further review. Additionally, MFD, with the assistance of IPRO, will review the medical records of recipients of these services to determine whether these services were properly authorized, appropriately provided and documented, and whether all available third-party insurance was exhausted prior to billing Medicaid for services rendered.

Since Hospice services are intended for people with a terminal diagnosis who are not expected to live more than six months, our Data Mining Unit will perform claim analysis to identify Medicaid recipients who have been in the hospice program for more than six months. In cases where there was no medical necessity from the start of services or the recipient's condition improves to the point that continued receipt of these services is no longer medically necessary, MFD will seek reimbursement. MFD data mining staff will also perform data match analysis, comparing different sets of billing claims to identify billing for duplicate services.

Laboratory Services

MFD Data Mining Unit will review whether independent clinical laboratories submitted claims for services where the laboratory tests already were included in the facility rate, or if laboratories submitted claims that improperly unbundled laboratory services. Unbundling occurs when a laboratory submits claims for separate services which should be submitted as a unit, at a lower reimbursement rate.

Managed Care

During FY 2012, MFD completed its first audit of a Special Investigations Unit (SIU) of one of the state's MCOs. The audit revealed several performance issues, including inadequate staffing, failure to report monetary recoveries accurately to the State, the initiation of an unreasonably small number of investigations and audits, and the failure to report potential fraud

and abuse issues discovered within other divisions of the MCO to the SIU for investigation. During FY 2013, MFD will audit two other MCOs' SIUs and will issue a report on our findings.

Since New Jersey now will be paying more in MCO capitation rates, issues may arise regarding capitation rate calculations. As such, MFD will perform a review of the documentation submitted by the MCOs to calculate their capitation rates. MFD will examine the MCOs' quarterly income statements including but not limited to the appropriateness of costs reported by the MCOs, encounter data and claim reports, to determine whether disallowed costs were reported to the State. Reviews will include, but will not be limited to:

- Identifying questionable encounter data MFD will analyze encounter data to identify patterns and trends that may reflect fraudulent claiming by providers.
 MFD will work with and assist SIUs to identify and report false billings by providers within the MCO networks.
- Auditing the credentialing process for providers applying to be in the MCO
 network, including whether the appropriate licensing, background and exclusion
 checks are being performed.
- Reviewing MCO clinical data to determine whether the cost of preventable health care such as hospital acquired conditions are improperly included in the MCOs' justification for rates.
- Reviewing, together with DMAHS, utilization data to determine whether
 payments included unnecessary costs incurred by MCOs. MFD will also work
 with MCOs to assess the fraud containment procedures in place to prevent MCOs
 from incurring unnecessary expenses.
- Reviewing supplemental maternity/newborn capitation payments and associated inpatient delivery costs for duplicative payments.
- Reviewing capitation payments for the same enrollee with multiple recipient identification numbers.

MFD's monitoring will also provide an opportunity to identify "best practices" which will be shared with DMAHS and the MCOs.

Medical Transportation

In 2009, DMAHS entered into a contract with a transportation broker to provide nonemergency medical transportation services for Medicaid recipients in selected counties in New Jersey as well as higher level transportation services statewide. The broker is responsible for providing all mobility assistance (vehicle/wheelchair/livery) transports in exchange for a set monthly capitation payment for every Medicaid client, regardless of whether the client uses the transportation services.

MFD will review whether the broker is in compliance with the contract in a number of areas, including but not limited to: its credentialing process; its reporting of provider deficiencies; its licensing and exclusion checks, including subcontractor exclusion checks; subcontractors' vehicle maintenance and driver supervision such as driver requirements; use of ambulances for non-emergency transportation; recipient eligibility for transportation, including medical necessity; verification of transportation; transportation to non-medical appointments; and verification of physician orders.

MFD will review ambulance providers' billings to ensure that services were rendered for only medically necessary/emergent services and that the ambulances had the proper equipment and personnel to provide emergency services. The review will also include a review of claims to ensure that the recipient was actually transported and that providers did not bill both the broker and Medicare/Medicaid for the same trip.

MFD also will review the following:

- Transportation Services during a Hospital Stay MFD will evaluate billed transportation services during a period when the enrollee was a hospital inpatient. MFD will determine whether services were provided in accordance with Medicaid requirements.
- Claim Review and Investigation MFD will review claims for transportation services to identify whether they were provided and if they were provided at a threshold of service beyond that which was deemed medically necessary.

Partial Care

The Partial Care (PC) Program was established to provide outpatient services to individuals with severe mental illnesses. The goal of PC is to eventually integrate patients into the community, though some patients may require the support of PC for a longer period of time.

MFD will review and audit claims submitted by PC providers to ensure that services were rendered in accordance with the patient's plan of care, the provider has sufficient documentation to substantiate billed services, appropriate documentation was maintained in patient and personnel related records, supervision was provided as required, and claims reflect services provided at least five days per week for up to five hours as required.

Personal Care Services

Personal care services are provided to persons with disabilities and chronic conditions of all ages, enabling them to accomplish tasks they would normally perform for themselves if they did not have a disability. MFD staff will audit personal care agencies to determine if these services were pre-authorized and provided in accordance with physician orders. We will also review whether appropriate care plans were developed and followed and whether services were performed by appropriately trained and certified and/or licensed staff.

Pharmacies

The Medicaid program reimburses pharmacies for a variety of prescription and over the counter medications. Risk areas in the pharmacy industry include drug diversion (the transfer of a prescription drug from lawful to an unlawful channel of distribution or use), buying back and reselling medication, and knowingly participating in illegal narcotics transactions. MFD will identify high risk pharmacies to ensure that billed services have been provided, will review purchase invoices to ensure that medication billed to the Medicaid program has been dispensed, and will verify whether purchases are from legitimate pharmaceutical wholesalers.

DMAHS has contracted with a third party vendor to conduct 1100 pharmacy audits per year and 1200 durable medical equipment provider audits per year. The vendor performs both desk and onsite audits, meets on a monthly basis with MFD and DMAHS to report its findings, and refers to MFD any findings that require either an investigation or an expanded audit. MFD

coordinates the audit process with the vendor to avoid duplication of work and to ensure that the audits are inclusive of the work that MFD would perform if it were conducting the audit.

Additionally, the MFD Audit Unit will perform the following tests to ensure that reimbursement for submitted claims was appropriate:

- Prescription Patterns MFD will identify prescription utilization patterns that are inconsistent with medical necessity. MFD will recommend that appropriate recipients be placed in the Lock In Program (restricting the pharmacy they may go to) in cases where fee for service payments are involved and will work cooperatively to assist MCOs in placing managed care enrollees who abuse prescriptions into the MCO restricted recipient program.
- Inventory Reviews MFD will conduct reviews to ensure that pharmacy inventory purchases less filled prescriptions to recipients matches in-stock inventory. A material difference could indicate fraudulent prescription claim submissions for reimbursement.
- **Drug Diversion** Drug diversion can take many forms, such as a prescriber who is over-prescribing, an act which allows an enrollee to sell excessive medication, or the forging of prescriptions by an enrollee with the intent to sell. MFD will identify frequent users of potentially diverted medications as well as pharmacists, prescribers, and other providers/enrollees who participate in drug diversion.

Finally, MFD will perform a review of the State's Medicaid Drug Rebate Information Program (DRIP). Under the program, a drug manufacturer is required to have a rebate agreement with the state's Medicaid program and the federal government. The agreement allows the Medicaid program to make available most of the manufacturer's drugs to Medicaid recipients. The manufacturer pays the state and federal government a rebate each time one of those drugs is dispensed to a Medicaid recipient. MFD's review will be to determine whether the state is receiving the appropriate amount of reimbursement from drug manufacturers.

The MFD Investigations Unit also will investigate pharmacies referred from the State's third party liability vendor for suspected fraud and/or abuse. The Investigations Unit will also proactively identify pharmacies to conduct invoice audits to verify the integrity of prescriptions

for scheduled II narcotics and related drugs in accordance with Board of Pharmacy regulations, policies and procedures.

Primary Care Physicians

In order to ensure that primary care providers are fulfilling their obligations, MFD will determine whether these physicians: are properly licensed, have not been excluded at the time treatment was provided or goods and services were ordered, do not resubmit previously denied claims under another physician's Medicaid number, and have documentation to support an existing physician-patient relationship to allow a physician order.

MFD will review records of non-Medicaid referring providers to determine whether there is sufficient medical necessity for services ordered that exceed \$50,000 per year, such as pharmaceuticals, laboratory tests, and durable medical equipment. For example, if a non-Medicaid provider, listed as a referring provider, writes a prescription that is not medically necessary and the Medicaid recipient fills the prescription at a Medicaid pharmacy, the physician who wrote the prescription will be liable to the State for reimbursement.

MFD will send letters to high-ordering physicians (i.e., physicians who exceed their peer group average in the amount or cost of services) alerting them to their ranking compared to other physicians in their peer group. The records for those physicians will be audited where appropriate. MFD will seek recoveries of amounts paid and impose sanctions on the provider of the service and/or ordering physician if overbillings have occurred.

Recipient Fraud/FamilyCare

MFD will continue to investigate recipient fraud cases involving New Jersey FamilyCare. Given that eligibility for FamilyCare is based on income level, those individuals who seek to defraud the FamilyCare system will distort their true income to become eligible for FamilyCare and, consequently, avoid paying for private health insurance. This type of fraud drains the resources of Medicaid dollars for those who truly are eligible for assistance.

In these economically challenging times, it is particularly crucial for MFD to evaluate eligibility determinations and confirm that only those who are in need of Medicaid assistance

receive it. MFD will continue to work with county prosecutors when conduct is criminal in nature to ensure that all appropriate recovery methods and sanctions are employed. During the previous fiscal year, MFD referred numerous investigations to county prosecutor's offices that resulted in arrests and prosecution of the individuals involved.

MFD will also continue to raise awareness of recipient fraud cases in order to send a message of deterrence and to encourage the public to report examples of recipient fraud to MFD. MFD will also work with DMAHS to address issues that arise concerning Medicaid eligibility criteria.

* * * * * * * * *

The Medicaid Fraud Division looks forward to a successful year of combating Medicaid fraud, waste and abuse. If you have any questions about the Medicaid Fraud Division's FY 2013 work plan, please contact:

Mark Anderson, Director Medicaid Fraud Division Office of the State Comptroller P.O. Box 025 Trenton, NJ 08625-0025 Telephone: 609-826-4700 Facsimile: 609-826-4801

www.nj.gov/comptroller/divisions/medicaid

If you suspect fraud, waste, or abuse in the Medicaid, FamilyCare or Charity Care programs, please contact: 1.888.937.2835 or email: njmedicaidfraud@osc.state.nj.us, or submit a form electronically through our website at www.nj.gov/comptroller/divisions/medicaid.